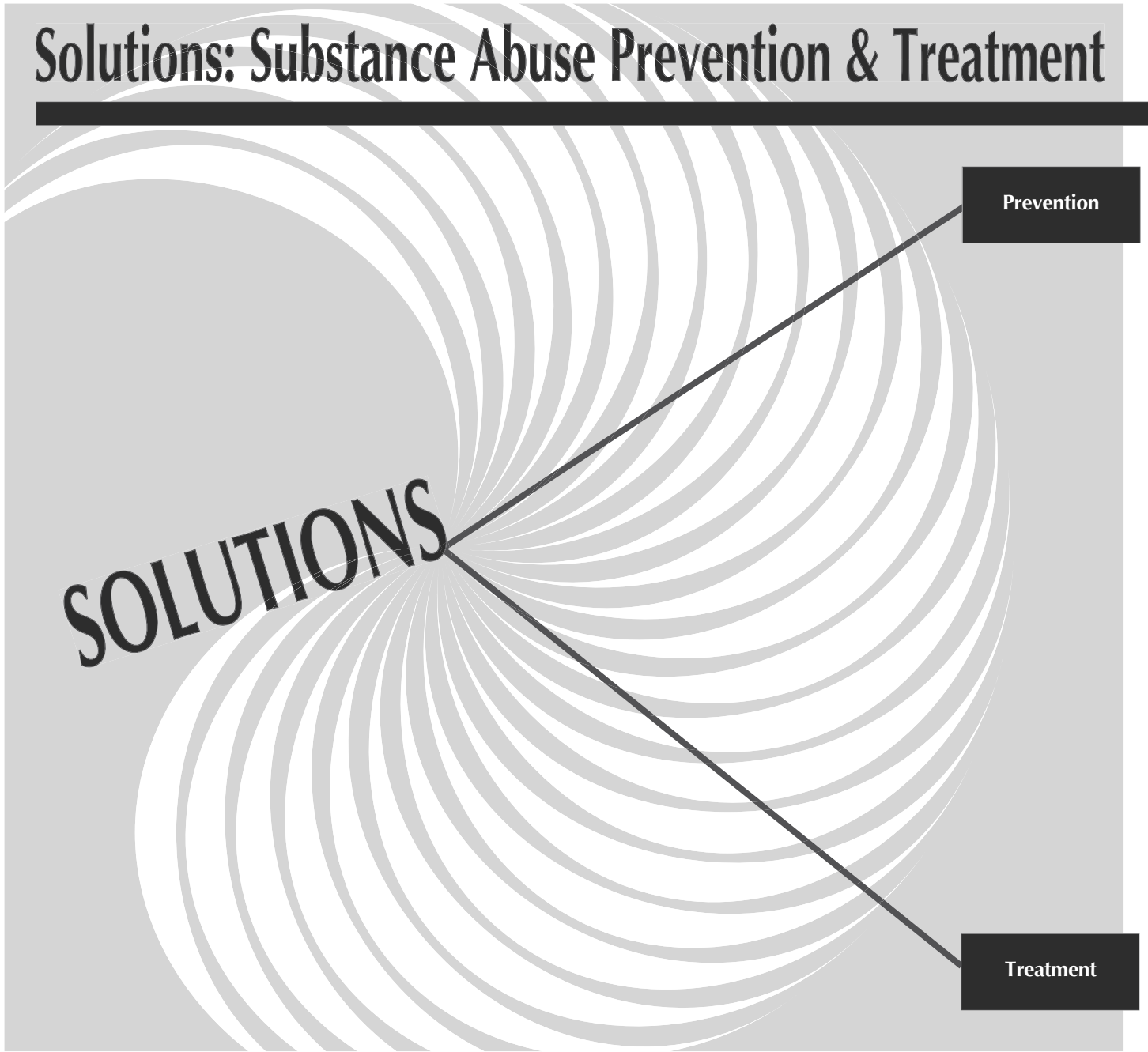
Solutions: Substance Abuse Prevention & Treatment



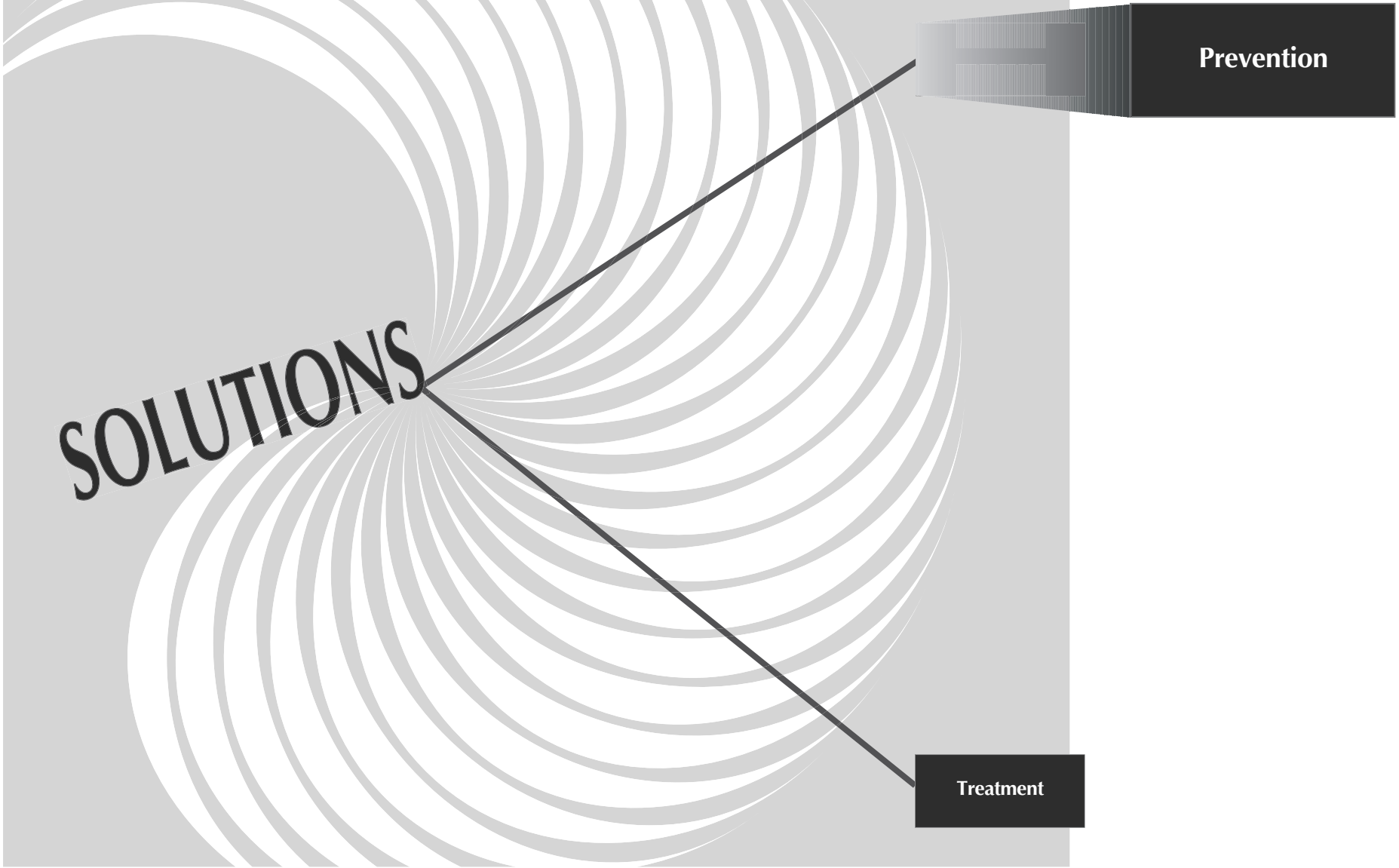
Introduction

State Law RCW 70.96A identifies the Division of Alcohol and Substance Abuse (DASA) as the "single state" agency for planning and delivery of substance abuse treatment and prevention services. All public substance abuse services funded by state or federal funds are either managed by DASA or operate in coordination with DASA (for example, services provided by the Department of Health, the Department of Licensing, the Department of Corrections, and the Office of the Superintendent of Public Instruction).

DASA does not provide direct prevention or treatment services, but rather, provides these services through contracts with county governments, Indian tribes, and non-profit service providers. The largest portion of available federal and state funds are contracted through county and tribal governments. Each biennium, DASA develops a plan for program development and prevention and treatment service strategies.

County governments and tribes are awarded prevention and treatment funds on the basis of a formula established by DASA in coordination with these governmental units. Counties and tribes are expected to conduct a needs assessment for prevention and treatment needs, based on the available funding and submit a plan to DASA. Contracts for community-based prevention and treatment services are written to include work statements specifying the activities which will be provided under the contracts.

Solutions: Substance Abuse Prevention & Treatment



Prevention

The Division of Alcohol and Substance Abuse's (DASA) Prevention Program is aimed at preventing alcohol, tobacco, and other drug use and abuse, reducing their negative consequences and, minimizing future needs for chemical dependency treatment.

DASA's prevention program covers all segments of the population at potential risk for drug and alcohol use and abuse. However, the primary focus is on children who have not yet begun use or are still only experimenting. Research indicates that youth who initiate alcohol and/or other drug use before the age of 15 are twice as likely to experience alcohol or drug problems than those who wait until after the age of 19.[1] The U.S. Surgeon General's 1994 Report, "Preventing Tobacco Use Among Young People", found that if adolescents are kept tobacco-free, they are extremely unlikely to take up tobacco use later in life.[2]

DASA has two main prevention goals: 1) delay onset of use; and 2) reduce alcohol, tobacco, and other drug misuse. DASA has also adopted performance measures for the 2003-2005 Biennium: to increase the number of children in each of three grades – 6th, 8th, and 10th – who have not used alcohol, tobacco, or marijuana in the past 30 days.

The Division's Philosophy

DASA has adopted a "risk and protective factor" approach as the cornerstone of its efforts to prevent alcohol and other drug abuse. Risk factors are personal, family or community characteristics that increase the likelihood an individual will use alcohol or other drugs. Protective factors are similar characteristics that help insulate individuals from substance-abusing behaviors.

Seventeen risk factors have been identified for substance use/abuse, in four major categories:

1. Community:

- Availability of alcohol, tobacco, and other drugs
- Community laws and norms favorable to substance use
- Transitions and mobility
- Low neighborhood attachment and disorganization
- Extreme economic deprivation

2. Family:

- Family history of substance abuse
- Family management problems
- Family conflict
- Favorable parental attitudes and involvement with substance abuse

3. School:

- Early and persistent antisocial behavior
- Academic failure beginning in elementary school
- Lack of commitment to school

4. Individual/Peers:

- Rebelliousness
- Friends who use
- Favorable attitudes towards substance use
- Early initiation of substance use
- Constitutional factors[3]

Protective factors include individual protective characteristics, bonding to family, school, community and/or peers, and healthy beliefs and clear standards for behavior.

DASA contracts with the Department of Social and Health Services' Office of Research and Data Analysis to compile risk and protection profiles for each of the 39 counties. These profiles provide substantial support to counties in program planning resource allocation, and the development of outcome measures.

[1] Developmental Research Programs (1996). Communities that care planning kit. Seattle, WA: Developmental Research Programs.
[2] U.S. Surgeon General (1994). Preventing tobacco use among young people: a report of the Surgeon General. Washington, DC: U. S. Department of Health and Human Services.
[3] Hawkins, J., Catalano, R. & Miller, J. (1992). Risk and protectivew factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse preventions. Psychological Bulletin. 112 (1), pp. 64-105.

Principles of Effective Substance Abuse Prevention

The field of substance abuse prevention is still young, and local capacity for thorough program evaluation tends to be limited. To address this need, the federal Center for Substance Abuse Prevention has developed a list of 78 scientifically defensible principles that can help prevention providers design and implement programs that work. The Division of Alcohol and Substance Abuse encourages prevention providers to make use of these principles in working to curb tobacco, alcohol, and drug use among Washington youth.[1]

Individual Domain

- Build social and personal skills.
- Design culturally sensitive interventions.
- Cite immediate consequences.
- Combine information dissemination and media campaigns with other interventions.
- Provide positive alternatives to help youth in high-risk environments develop personal and social skills in a natural and effective way.
- Recognize that relationships exist between substance use and a variety of other adolescent health problems.
- Incorporate problem identification and referral into prevention programming.
- Provide transportation to prevention programs.

Family Domain

- Target the entire family.
- Help develop bonds among parents in programs; provide meals, transportation, and small gifts; sponsor family outings; and ensure cultural sensitivity.
- Help minority families respond to cultural and racial issues.
- Develop parenting skills.
- Emphasize family bonding.
- Offer sessions where parents and youth learn and practice skills.
- Train parents to both listen and interact.
- Train parents to use positive and consistent discipline techniques.

[1] Detailed descriptions of each principle can be found at: www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf

Family Domain (continued)

- Promote new skills in family communication through interactive techniques.
- Employ strategies to overcome parental resistance to family-based programs.
- Improve parenting skills and child behavior with intensive support.
- Improve family functioning through family therapy when indicated.
- Explore alternative community sponsors and sites for schools.
- Videotape training and education.

Peer Domain

- Structure alternative activities and supervise alternative events.
- Incorporate social and personal skill-building opportunities.
- Design intensive alternative programs that include a variety of approaches and substantial time commitment.
- Communicate peer norms against use of alcohol and illicit drugs.
- Involve youth in the development of alternative programs.
- Involve youth in peer-led interventions, or interventions with peer-led components.
- Counter the effects of deviant norms and behaviors by creating an environment for youth with behavior problems to interact with other nonproblematic youth.

School Domain

- Avoid relying solely on knowledge-oriented interventions designed to supply information about negative consequences.
- Correct misconceptions about the prevalence of use in conjunction with other education approaches.
- Involve youth in peer-led interventions or interventions with peer-led components.
- Give students opportunities to practice newly acquired skills through interactive approaches.
- Help youth retain skills through booster sessions.
- Involve parents in school-based approaches.
- Communicate a commitment to substance abuse prevention in school policies.

Community Domain

- Develop integrated, comprehensive prevention strategies rather than one-time community-based events.
- Control the environment around schools and other areas where youth gather.
- Provide structured time with adults through mentoring.
- Increase positive attitudes through community service.
- Achieve greater results with highly involved mentors.
- Emphasize the costs to employers of workers' substance use and abuse.
- Communicate a clear company policy on substance abuse.
- Include representatives from every organization that plays a role in fulfilling coalition objectives.
- Retain active coalition members by providing meaningful rewards.
- Define specific goals and assign specific responsibility for their achievement to subcommittees and task forces.
- Ensure planning and clear understanding for coalition effectiveness.
- Set outcome-based objectives.
- Support a large number of prevention activities.
- Organize at the neighborhood level.
- Assess progress from an outcome-based perspective and make adjustments to the plan of action to meet goals.
- Involve paid coalition staff as resource providers and facilitators rather than as direct community organizers.

Society/Environmental Domain

- Develop community awareness and media efforts.
- Use mass media appropriately.
- Provide structured time with adults through mentoring.
- Avoid the use of authority figures.
- Broadcast messages frequently over an extended period of time.
- Broadcast messages through multiple channels when the target audience is likely to be viewing or listening.
- Disseminate information about the hazards of a product or industry that promotes it.

Society/Environmental Domain (continued)

- Promote replacement of more conspicuous labels.
- Promote restrictions on tobacco use in public places and private workplaces.
- Promote clean indoor air laws.
- Combine beverage server training with law enforcement.
- Combine beverage servers' legal liability with laws against service to intoxicated patrons and against sales to minors.
- Increase the price of alcohol and tobacco through excise taxes.
- Increase minimum purchase age for alcohol to 21.
- Limit the location and density of retail alcohol outlets.
- Employ neighborhood anti-drug strategies.
- Enforce minimum purchase age laws using undercover buying operations.
- Use community groups to provide positive and negative feedback to merchants.
- Employ more frequent enforcement operations.
- Implement "use and lose" laws.
- Enact deterrence laws and policies for impaired driving.
- Enforce impaired-driving laws.
- Combine sobriety checkpoints with positive passive breath sensors.
- Revoke licenses for impaired driving.
- Immobilize or impound vehicles of those convicted of impaired driving.
- Target underage drivers.

Children's Transition Initiative (CTI)

Based on statewide risk and protective factor data, and prevalence data collected through the 1998 Washington State Adolescent Health Behavior Survey, DASA has begun piloting a new Children's Transition Initiative (CTI) in seven counties. Survey data show a sharp rise in youth alcohol, tobacco, and marijuana use between grade school and middle school, and again between middle school and high school. National research findings demonstrate the benefits of providing prevention services to youth over time. These findings provide the basis for CTI, the goal of which is to prevent children, ages 9 to 16, from using alcohol, tobacco, marijuana, and other drugs.

Through CTI, existing county programs will identify discrete youth populations at high risk for drug initiation. Prevention programming will be specifically tailored for each group, depending on individual risk factors, protective factors, and assets.

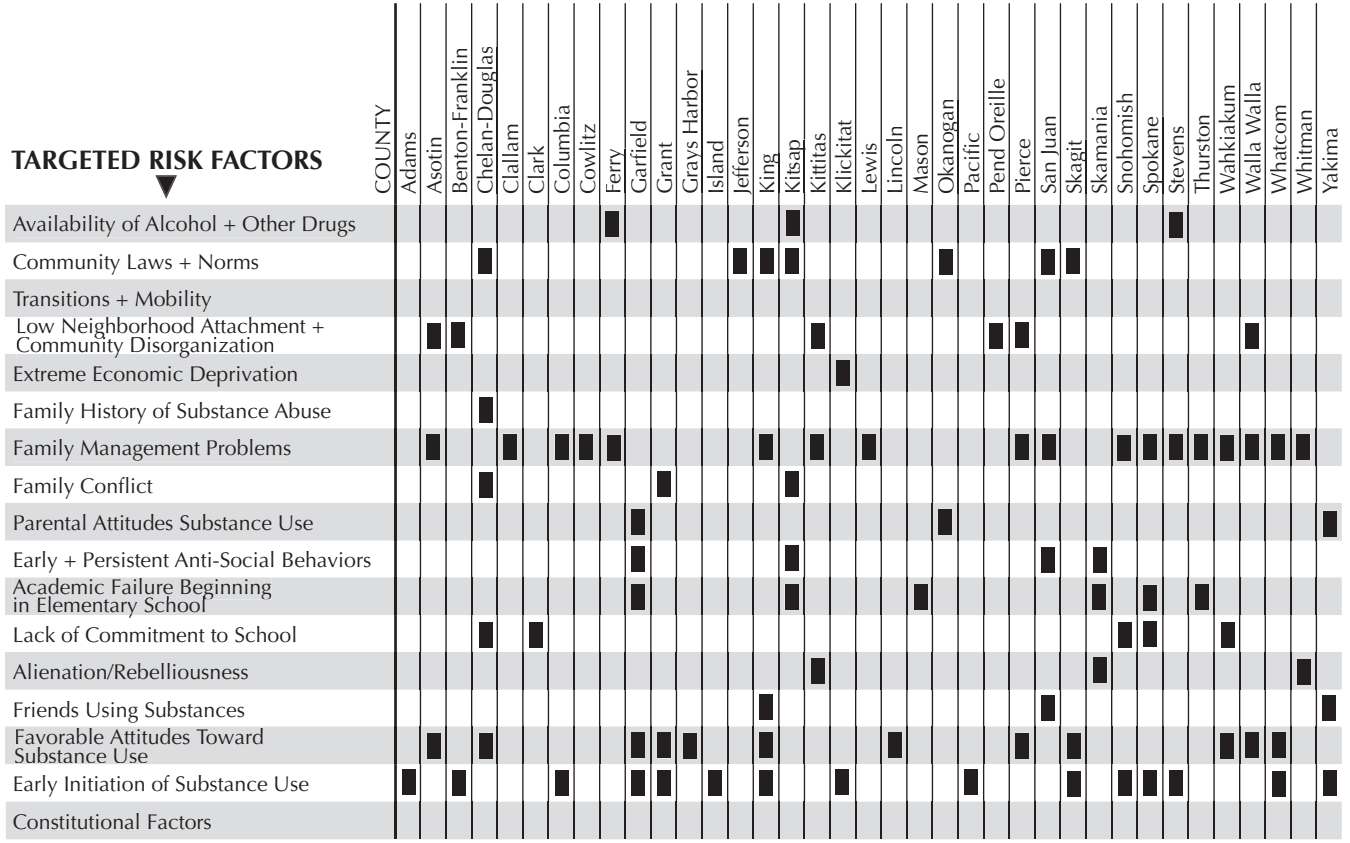
The following primary outcomes have been identified for CTI:

- Enrolled youth will demonstrate a significantly higher rate of abstinence from alcohol, tobacco, marijuana, and other drugs than non-enrolled youth with similar risk factors, protective factors, and assets.
- There will be a 50% increase in the awareness of risk and protective factors associated with substance abuse by parents or caregivers of CTI-participating children.
- 80% of children enrolled in CTI will be retained in the initiative for a minimum of 12 months.

Secondary outcomes will be negotiated between DASA and counties, and may include targeted risk and protective factors in the school, family, peer, or community domains. From July 1999 through January 2002, 265 children and families have been enrolled in CTI services in the following counties: Benton, Franklin, Columbia, Grant, Island, Lincoln, Spokane, Skamania, Whatcom, Pierce, Lewis, and Clark.

County Prioritized Risk Factors

The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by each of the 39 counties in Washington State.



Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.

County Prioritized Protective Factors

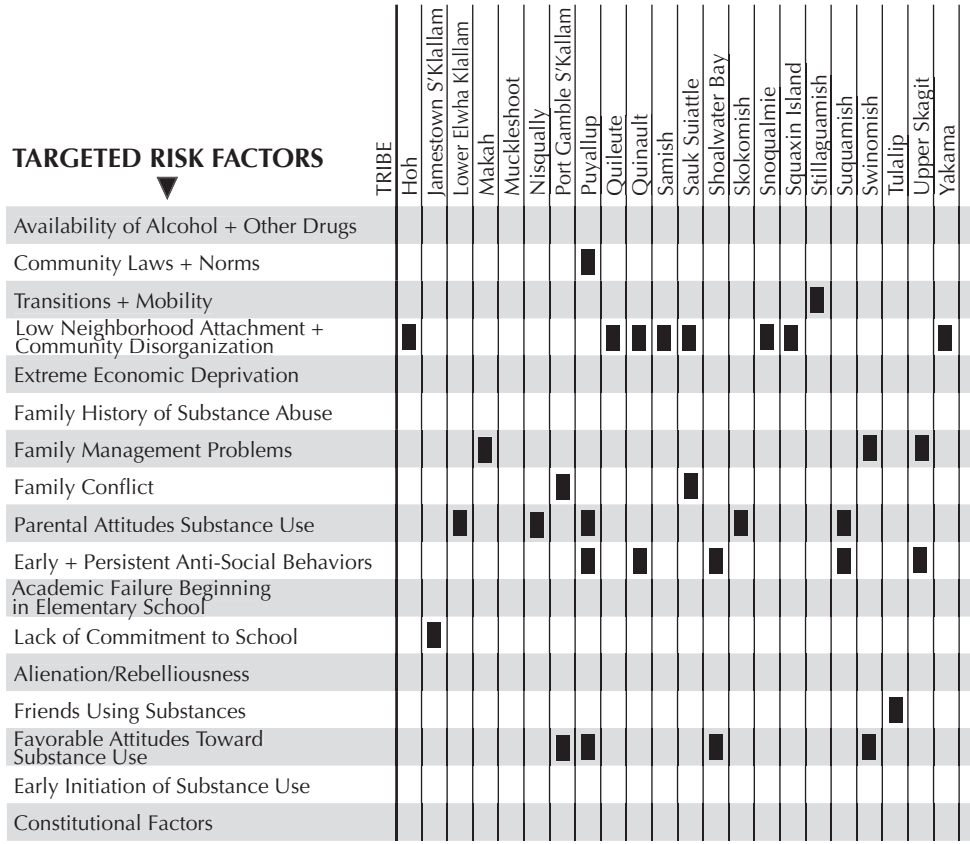
The table below displays a summary of prioritized protective factors for the 2003-2005 Biennium being addressed by each of the 39 counties in Washington State.

TARGETED RISK FACTORS ▼ / COUNTY	Adams	Asotin	Benton-Franklin	Chelan-Douglas	Clallam	Clark	Columbia	Cowlitz	Ferry	Garfield	Grant	Grays Harbor	Island	Jefferson	King	Kitsap	Kittitas	Klickitat	Lewis	Lincoln	Mason	Okanogan	Pacific	Pend Oreille	Pierce	San Juan	Skagit	Skamania	Snohomish	Spokane	Stevens	Thurston	Wahkiakum	Walla Walla	Whatcom	Whitman	Yakima
Healthy Beliefs & Clear Standards		■	■	■			■			■	■	■	■	■	■			■		■			■			■	■		■	■						■	■
Community Building																																					
Opportunity											■					■	■							■			■							■	■		
Skills																																					
Recognition	■			■							■														■		■		■		■						
Family Bonding				■	■		■	■	■		■					■	■		■				■							■	■	■	■	■	■		
Opportunity				■	■		■	■	■		■				■	■	■		■				■			■				■	■	■	■	■	■		■
Skills					■		■	■	■		■					■	■		■				■							■	■	■	■	■			
Recognition					■		■	■	■		■					■	■		■			■	■							■	■	■	■	■	■		
School Bonding				■		■									■	■					■	■	■		■			■	■	■	■	■	■		■		
Opportunity				■		■	■								■	■					■	■	■		■			■	■	■	■	■	■		■		
Skills				■		■									■	■					■	■	■		■			■	■	■	■	■	■		■		
Recognition				■		■									■	■					■	■	■		■			■	■	■	■	■	■		■		
Peer Bonding													■				■								■		■							■	■		■
Opportunity													■				■								■		■							■	■		■
Skills		■		■							■		■		■		■								■	■	■						■	■	■		■
Recognition													■				■								■		■							■	■		■

Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.

Tribal Prioritized Risk Factors

The table below displays a summary of the prioritized risk factors for the 2003-2005 Biennium being addressed by 22 tribes in Washington State that have prevention contracts with the Division of Alcohol and Substance Abuse.



Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.

Tribal Prioritized Protective Factors

The table below displays a summary of the prioritized protective factors for the 2003-2005 Biennium being addressed by 22 tribes in Washington State that have prevention contracts with the Division of Alcohol and Substance Abuse.

TARGETED RISK FACTORS ▼ / TRIBE	Hoh	Jamestown S'Klallam	Lower Elwha Klallam	Makah	Muckleshoot	Nisqually	Port Gamble S'Kallam	Puyallup	Quileute	Quinault	Samish	Sauk Suiattle	Shoalwater Bay	Skokomish	Snoqualmie	Squaxin Island	Stillaguamish	Suquamish	Swinomish	Tulalip	Upper Skagit	Yakama
Healthy Beliefs & Clear Standards																						
Community Building																						
Opportunity															■							
Skills																						
Recognition					■																	
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Recognition																						
Peer Bonding																						
Opportunity																						
Skills												■										
Recognition																						

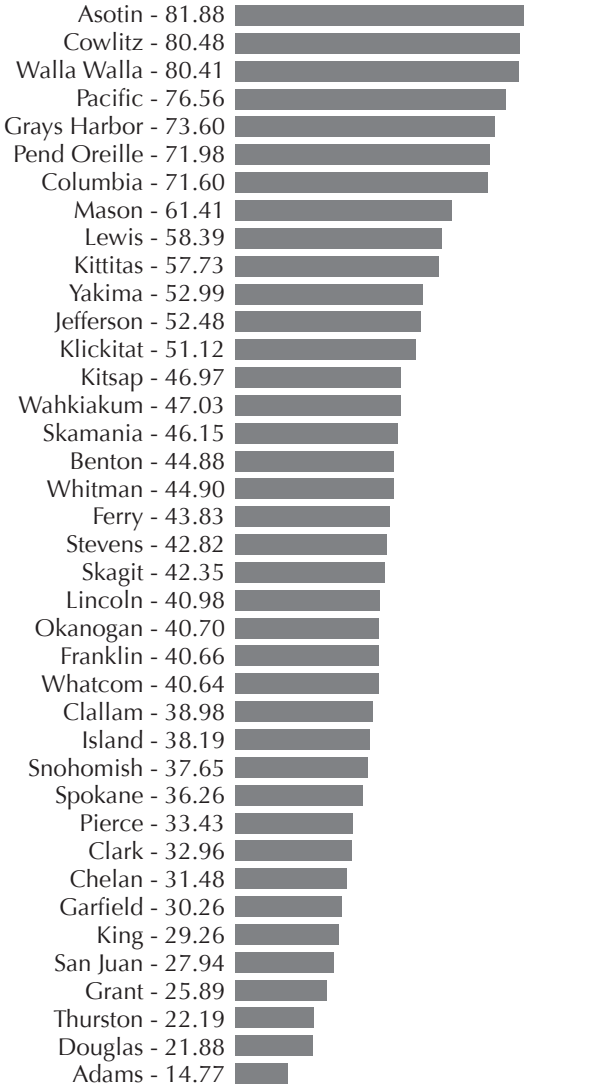
Source: Data compiled from Division of Alcohol and Substance Abuse quarterly reports.

Risk Factor: Family Management Problems – Victims of Child Abuse and Neglect

Poor family management practices include lack of clear expectations for behavior, failure of parents to know where their children are and who they are with, and excessively severe or inconsistent consequences for negative behaviors. These practices have been shown to increase the risk of drug abuse, delinquency, teen pregnancy, school dropout, and violence.

Successful management intervention strategies focus on developing parenting skills, and emphasize family bonding. These programs often have sessions in which parents and youth learn and practice skills both separately and together.

Rates of Accepted Referrals for Child Abuse and Neglect (5-Year Average -- Per 1,000 Children)



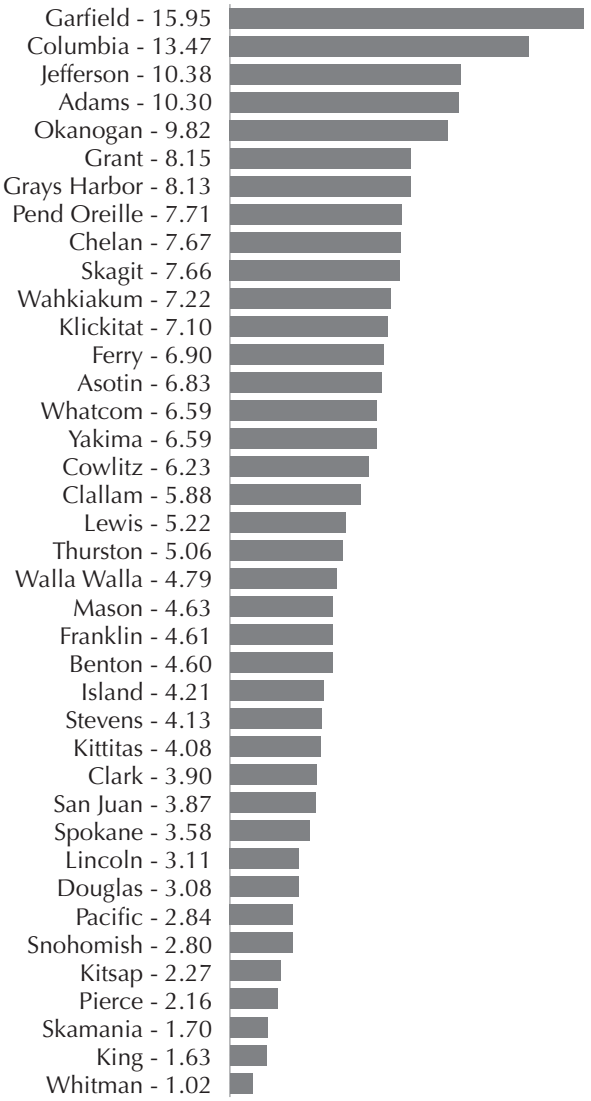
Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Risk Factor: Early Initiation of Problem Behavior – Alcohol- or Drug-Related Arrests (Ages 10-14)*

The earlier young people begin using drugs, engaging in violent activity, committing crimes, dropping out of school, and becoming sexually active, the greater the likelihood they will have problems with these behaviors later on. Due to the compelling nature of the evidence, many planners target 'age-of-first-use' for prevention efforts. Communities seek to reduce risk factors that lead to early experimentation and provide children with skills necessary to resist substance use.

**It should be noted that arrest data may reflect a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of drug-related criminal activity.*

Rates of Alcohol- or Drug-Related Arrests, Adolescents Ages 10-14
(5-Year Average -- Per 1,000 Adolescents Ages 10-14)

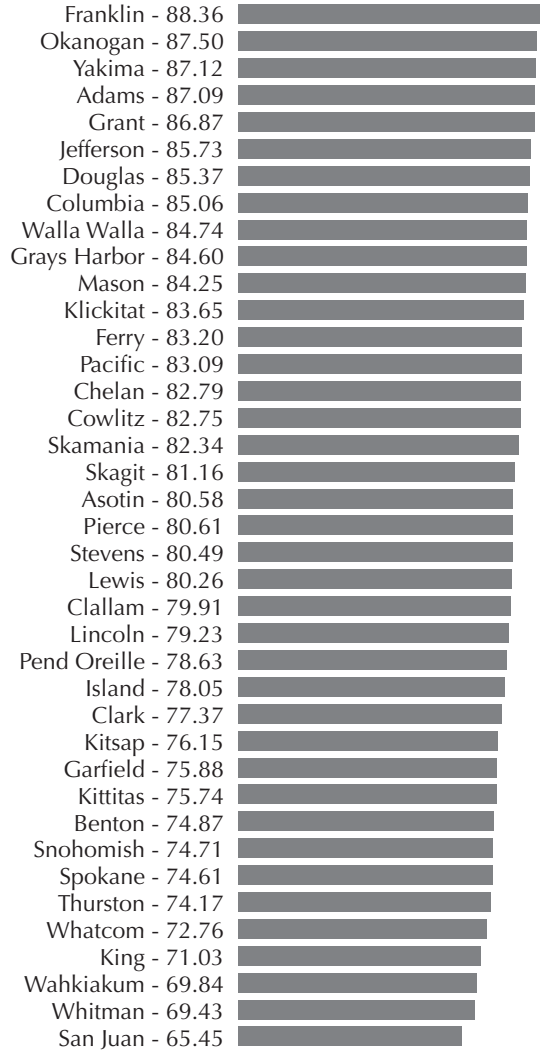


Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Risk Factor: Low School Achievement – Poor Academic Performance

Beginning in fourth and fifth grades, academic failure increases the risk of substance abuse as children continue on in school. Children experience academic failure for many reasons. Many researchers believe that risk factors increase when students are unable to experience some satisfaction from their academic efforts. Prevention programs focus on academic skill-building through after-school programs, and improving children's early learning opportunities. Communities and families must partner with schools so that all children can become achievers.

Rates of Fourth Graders Who Failed One or More Content Areas in the Washington Assessment of Student Learning (WASL) (5-Year Average -- Per 1,000 Fourth Graders)



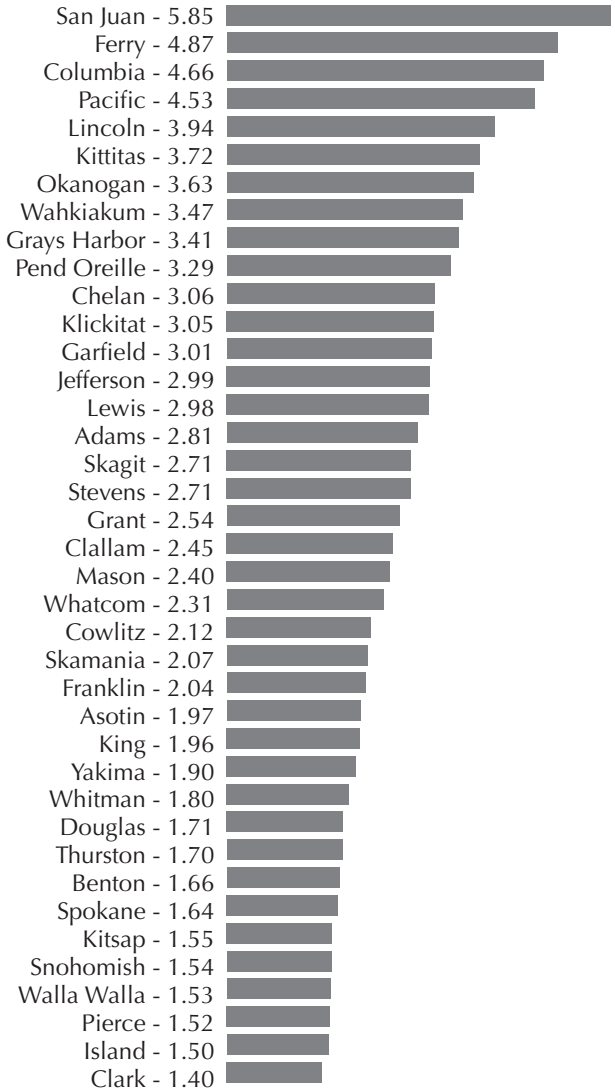
Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Risk Factor: Availability of Drugs – Alcohol Retail Licenses

Among adults, research has shown that alcohol use is associated with availability, including the number of outlets at which it can be purchased. No data on illicit drug availability is readily available.

In many communities across the state, coalitions of law enforcement, Liquor Control Board agents, prevention professionals, schools, and others have worked to increase enforcement of underage purchase laws. Recent data suggest that as youth perceive increased difficulty in purchasing alcohol, alcohol use declines.

Rates of Active Alcohol Retail Licenses
(5-Year Average -- Per 1,000 Persons)



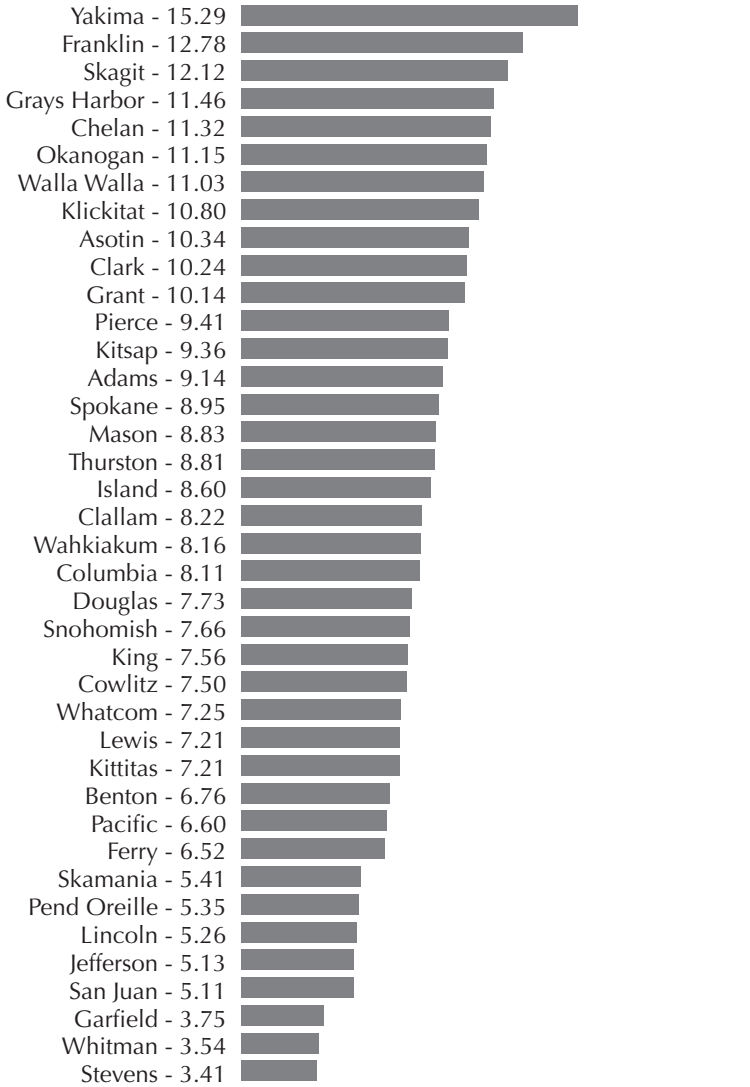
Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Risk Factor: Low Commitment to School – High School Dropouts

Children with low commitment to school, low educational aspirations, and poor motivation are at risk for problem behaviors. It is likely that youth who perform poorly academically fail to develop bonds to school, and will have lower expectations of success.

Efforts to reduce this risk factor encompass community, family, and school, as well as children and youth themselves. Prevention efforts in a community would seek to raise the value placed on education. Parents can be taught skills for encouraging and supporting their child's education. Mentoring programs can also assist youth in setting future-oriented goals.

Rates of Number of Students Grades 9-12 Who Dropped Out of School in a Single Year (5-Year Average -- Per 100 Students)



Source: Community Outcome and Risk Evaluation Geographic Information System (CORE-GIS), Washington State Department of Social and Health Services, Research and Data Analysis, 2003.

Statewide Prevention Services

The Division of Alcohol and Substance Abuse (DASA) provides prevention services primarily by way of interagency agreements and partnerships with other state agencies. The following programs are either partially or fully funded by DASA:

Washington State School-Based Prevention and Intervention Services Program

The Office of Superintendent of Public Instruction (OSPI) administers a school-based program targeting students at risk for developing alcohol, tobacco, and other drug related problems. During the 2001-2003 Biennium, the Prevention and Intervention Services Program was implemented by 13 local grantees across Washington State. Geographically, these grantees covered all regions of the state. Some 292 intervention specialists delivered services to 22,947 K-12 students in 765 schools.

Survey of Adolescent Health Behaviors

OSPI administers an adolescent health behaviors survey in Washington schools every two years. The survey represents a collaborative effort among OSPI, DASA, Department of Health, and the Department of Community, Trade and Economic Development. Alcohol, tobacco, and other drug use prevalence and risk/protective factor data are generated from this survey and used by prevention planners and service providers throughout our state. The 2002 Survey of Adolescent Health Behaviors was the seventh statewide survey. The most recent survey was conducted in the fall of 2002. More than 137,000 students in 752 schools in 6th, 8th, 10th and 12th grades took the survey, and nearly 25,000 students were included in the state sample.

Reducing Underage Drinking Initiative (RUaD)

In 1998, the Washington State Coalition to Reducing Underage Drinking (RUaD) was established to oversee the implementation of program components delineated in Washington State's proposals to the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Enforcing the Underage Drinking Laws (EUDL) program. Since 1999, over $2.2 million dollars has been awarded to Washington State. EUDL funding to Washington State supports programs including; compliance checks of retail outlets; the training of merchants to recognize fake IDs; police emphasis patrols; media campaigns; education to minors about the consequences of underage drinking; and school-based alcohol use prevention programs utilizing best practices. Communities currently receiving EUDL funds in Washington State include: City of Kent, Washington State and Western Washington Universities, and Kitsap, Mason, Chelan, Douglas, Benton, Franklin, and Grays Harbor Counties.

Reducing Access to Tobacco Products (Synar Regulation)

The federal Substance Abuse Prevention and Treatment (SAPT) block grant requires that states focus on reducing youth access to tobacco products through retail outlets. The so-called Synar Amendment requires states to reach and maintain a maximum 20% non-compliance rate as measured through compliance checks. The Division of Alcohol and Substance Abuse (DASA) coordinates with two other state agencies – the Department of Health (DOH) and Liquor Control Board (LCB) – to implement youth tobacco compliance checks that meet Synar rules established by the federal Center for Substance Abuse Prevention. DOH develops a randomized list of tobacco retailers in the state. Local health departments and districts organize and implement the youth access compliance checks. DOH uses the results of the local health jurisdictions' compliance checks to calculate an overall state compliance rate. LCB provides technical assistance and enforcement follow-up for local youth access checks.

In 1995, when the first Synar checks were conducted, the State's non-compliance rate was 25.1%. Since 1999, non-compliance rates have ranged from 11.2-13.9%, well within that required under Synar.

Washington State Substance Abuse College Coalition

The University of Washington facilitates the Washington State Substance Abuse College Coalition. The Coalition was established to facilitate the development, implementation and continuation of substance abuse prevention programming at all college and university campuses in Washington State. Coalition members administer campus-based prevention services targeting students and university communities. The Coalition meets six times during the academic year on different campuses throughout the state, and sponsors the annual Pacific Northwest Conference on Collegiate Wellness. The Coalition recently authored a report to college presidents with information about the Coalition, its recent efforts, and plans for a statewide initiative to address alcohol and other drug abuse on college campuses.

Washington State Alcohol/Drug Clearinghouse

The Washington State Alcohol/Drug Clearinghouse provides accurate and timely resource materials and information on alcohol, tobacco, and other drug abuse prevention. Materials and information are accessible for Washington State residents, including non-English speaking individuals and persons with disabilities. The Clearinghouse maintains a statewide toll-free phone number for individuals requesting resources, including a system for receiving requests by telephone from the hearing-impaired community. There is also a 24-hour response protocol, and a video library. The Clearinghouse serves as Washington State's Regional Alcohol and Drug Awareness Resource (RADAR) Network State Center, and provides services in accordance with RADAR guidelines developed by the National Clearinghouse for Alcohol and Drug Information. The Clearinghouse also distributes an electronic newsletter to communicate information about prevention practices and activities/campaigns to individuals and organizations in Washington State. The Clearinghouse fulfills some 8,000 requests for resources each biennium.

Communications and Media Program

The purpose of the Communications and Media program is to educate youth, parents, policymakers and other members of the public about the connection between substance abuse and health and social problems, effective ways to prevent and reduce alcohol and drug abuse; and ways to access prevention and treatment resources in Washington State.

The program consists of the following elements:

- **Partnership for a Drug Free Washington (PDFW)**: An ongoing media campaign to disseminate effective prevention messages via multi-media advertising, and provide drug abuse education materials for educators, parents, and youth.
- **FOCUS Newsletter**: A quarterly publication providing news, resources, and information for advancing the field of substance abuse prevention and treatment in Washington State.
- **Resources for Promoting Community-Based Awareness Events:** DASA partners with state and community agencies to sponsor activities and provide resources for Drug Free Washington Month, National Alcoholism and Drug Addiction Recovery Month, and other events.
- **Media Relations**: DASA provides information about new research, resources, and key events to the news media, and responds promptly to all media inquiries.

Washington State Mentoring Initiative

The Washington State Mentoring Partnership serves as a prevention network sponsored by DASA to expand the field of mentoring throughout Washington State, increase societal awareness regarding the benefits of mentoring, and expand private sector participation. The Washington State Mentoring Partnership is comprised of mentoring program administrators, service providers, and advocates. DASA provides technical assistance to prevention planners and providers interested in developing local mentoring programs. In 2002, both the Governor's and Lieutenant Governor's Offices participated in National Mentoring Month activities.

Children's Transition Initiative (CTI)

DASA established the Children's Transition Initiative (CTI) to encourage prevention providers to address the risk and protective factors in children transitioning from grade school to middle school and middle school to high school. CTI requires enrollment of children and their families for a minimum of 12 months, and the utilization of research-based prevention strategies. CTI counties include: Benton, Columbia, Ferry, Franklin, Grant, Island, Lincoln, Skamania, Spokane, and Whatcom.

Preliminary results are promising. Of the 64 youth who participated in CTI for the first year: 36% showed improvement in family management issues; 31% reported more appropriate attitudes regarding drug use; 31% reported fewer relationships with friends who used alcohol or other drugs; and 67% resisted the trend among their age group to increase alcohol and drug experimentation.

Washington State Exemplary Substance Abuse Prevention Awards

The Washington State Exemplary Substance Abuse Prevention Awards Program recognizes outstanding substance abuse prevention programs, individuals working in the prevention field, and media organizations that support prevention efforts. A review committee evaluates the applications received and approves those meeting the selection criteria. Members of the committee also nominate and select additional individuals for their special contributions to the field. Awardees are honored at the Washington State Prevention Summit in Yakima. The state awards process is designed to coordinate with the existing national awards process, with the goal of identifying Washington State Exemplary Programs that could be encouraged to apply at the national level.

Community Prevention Training System (CPTS)

The Community Prevention Training System (CPTS) provides financial support to counties and tribes for capacity building so that they will be able to deliver prevention services which represent science-based "best and promising practices". CPTS funds are not intended to support prevention programs. Rather, they are intended to ensure that communities are able to take advantage of, or make available, trainings that enhance the level of expertise and knowledge of the latest prevention research. Efforts are made to ensure that all prevention contractors have access to the fund. Some 30 counties and seven tribes applied for and received CPTS support during the past Biennium, with funds matched by the counties and tribes themselves.

Washington State Incentive Grant

In July 1998, Governor Gary Locke received a four-year, $8.9 million State Incentive Grant (SIG) awarded by the federal Center for Substance Abuse Prevention. The grant was used to fund initiatives to reduce youth alcohol, tobacco, marijuana, and other drug use; reduce factors that put youth in grades 4-10 at risk for substance abuse; and enhance factors that provide protection for youth against these risks. The Division of Alcohol and Substance Abuse (DASA) was designated as the lead agency managing the grant, with the Department of Social and Health Services' Research and Data Analysis Division as the primary evaluator.

Washington State Substance Abuse Prevention System

In March 2001, Governor Locke issued a document titled *Washington State Incentive Grant Substance Abuse Prevention System.* Prepared by the 32-member Governor's Substance Abuse Advisory Committee, the document included signed commitments by the directors of state agencies, councils, commissions, and boards involved in substance abuse prevention "to work together to address Washington State's overarching objectives and institute strategies for a State Substance Abuse Prevention System."

Participating state entities include the Governor's Executive Policy Office, Office of the Lieutenant Governor, Department of Social and Health Services, Office of Superintendent of Public Instruction, Office of Community, Trade & Economic Development, Department of Health, Liquor Control Board, Governor's Juvenile Justice Advisory Committee, Family Policy Council, Washington State Traffic Safety Commission, Governor's Council on Substance Abuse, and Citizens Advisory Council on Alcoholism and Drug Addiction.

State Incentive Grant Objectives

In March 1999, the Governor's Substance Abuse Prevention Advisory Committee, and Governor Locke issued, a Washington State Substance Abuse Prevention Plan. The goal of the Plan is to "streamline state-level prevention systems to coordinate resources and reduce duplication of effort." Below is a table listing the six objectives of the Plan and steps being taken to address them.

Approved March 1999	Approved March 2001
Objective 1 To identify and adopt a set of common outcome measures building on the emerging consensus of a "science-based" risk and protective factor approach to prevention.	**Participating state agencies** reached agreement to work on 18 overarching state outcome objectives and corresponding benchmark objectives. The Governor's Council on Substance Abuse is the lead designated to prepare "report" cards on the progress of reaching the benchmarks every two years.
Objective 2 To develop and coordinate administration of common community needs and resource assessment tools.	**Participating state agencies** reached agreement to expand the existing Community Outcome Risk Evaluation Geographic Information System currently being managed by the Department of Social and Health Services, Research and Data Analysis Division to collect the data necessary to track the overarching state outcome objectives.
Objective 3 To define selection criteria to identify the science-based prevention programs which can best address the needs identified from common assessment and measures.	**The Western Center for the Application of Prevention Technology (WestCAPT)** is the lead for ensuring that community prevention providers have access to current information on science-based prevention programs and programs with promising approaches. At the present time, detailed information is available on CD ROM and via the Internet at http: //www.unr.edu/westcapt/.
Objective 4 To develop uniform reporting mechanisms which can capture outcomes of individual community prevention programs.	**The SIG Community Projects** are continuing to field-test a prevention outcome evaluation and monitoring system called *Everest*. The goal is to have this system available to interested prevention providers from participating state agencies and from the community at large. *Everest* is a Web-enabled system that: (1) Generates pre/post tests designed to measure outcomes of participants in prevention programs; (2) Provides a confidential screen for input of the test results; (3) Matches the pre-and post information; and (4) Immediately generates a series of outcome reports.
Objective 5 To develop guidelines for leveraging and redirecting money and resources based on the confidence of the scientifically established outcome measures, uniform community assessments, and reliable reporting.	**Participating state agencies** have achieved tremendous accomplishments through collaboration. In addition to working together on the various aspects of the objectives as described, the state agencies achieved the following: (1) Consolidated administration of school-based adolescent health behavior survey to be administrated every two years in the fall of the second year of the state biennial cycle; and (2) Administrated collaborative community needs assessment that allowed for one assessment to be jointly conducted on the local level and submitted for use by multiple funding state agencies.
Objective 6 To create a system for continuous professional development for all prevention providers, both volunteer and paid.	**The Western Center for the Application of Prevention Technology (WestCAPT)** is the lead for ensuring that community prevention providers have access to training that will prepare them on the most current findings related to prevention and implementation of science-based prevention programs and programs with promising approaches. WestCAPT is developing a state calendar for training opportunities.

In the development of the State Incentive Grant State Substance Abuse Prevention System, 18 objectives were set, and responsibility assigned to those state agencies expected to take the lead in moving the state toward meeting those objectives.

State Incentive Grant Overarching Outcomes and Benchmark Objectives

#	Desired Outcome Objectives	Baseline	Targeted State Benchmarks	Long-range	Short-range	CTED	DOH	DSHS	FPC	GJJAC	LCB	OSPI	WTSC
	SAFETY												
1.	Reduce alcohol-related motor vehicle crash deaths.	1997 4.74 per 100,000	4.0 per 100,000		X			•			•		•
2.	Reduce illicit drug-related deaths.	1998 5.93 per 100,000	3 per 100,000		X			•					
3.	Reduce the number of young people in Grades 9 through 12 who reported that they rode, during the previous 30 days, with a driver who had been drinking alcohol.	1999 29%	25%	X		•		•			•		•
4.	Increase the percentage of students reporting that they feel safe in school.	2000 Grade 6 - 86% Grade 8 - 77.4% Grade 10 - 77.5% Grade 12 - 85%	Grade 6 - 90% Grade 8 - 90% Grade 10 - 90% Grade 12 - 90%	X						•		•	
5.	Reduce the percentage of youth at risk because they do not perceive communities as having strong laws and norms against substance use.	2000 Grade 6 - 37.5% Grade 8 - 33.3% Grade 10 - 44.1% Grade 12 - 42.3%	Grade 6 - 25% Grade 8 - 25% Grade 10 - 30% Grade 12 - 30%	X		•	•	•			•	•	
	SENSE OF BELONGING												
6.	Improve bonding and strong attachment to family. (Data for this objective are available for limited communities in the state, not a representative sample.)	1995 Grade 6 - 83% Grade 8 - 71% Grade 10 - 66% Grade 12 - 70%	Grade 6 - 90% Grade 8 - 80% Grade 10 - 75% Grade 12 - 75%	X		•		•		•			
	SOCIAL INTEGRATION INTO COMMUNITY												
7.	Increase opportunities for pro-social involvement of youth in their community.	1998 Grade 6 - 42.4% Grade 8 - 56.5% Grade 10 - 48.9% Grade 12 - 47.1%	Grade 6 - 75% Grade 8 - 75% Grade 10 - 75% Grade 12 - 75%	X		•	•	•		•		•	
8.	Increase rewards for pro-social involvement in the community.	1998 Grade 6 - 67.4% Grade 8 - 52.6% Grade 10 - 55.7% Grade 12 - 51.5%	Grade 6 - 75% Grade 8 - 75% Grade 10 - 75% Grade 12 - 75%	X		•		•		•		•	

Agency Acronyms: CTED – Community, Trade and Economic Development • **GJJAC** – Governor's Juvenile Justice Advisory Committee • **DOH** – Department of Health • **LCB** – Liquor Control Board
DSHS – Department of Social and Health Services • **OSPI** – Office of Superintendent of Public Instruction • **FPC** – Family Policy Council • **WTSC** – Washington Traffic Safety Commission

#	Desired Outcome Objectives	Baseline	Targeted State Benchmarks	Long-range	Short-range	CTED	DOH	DSHS	FPC	GJJAC	LCB	OSPI	WTSC
	LEARNING AND SKILL BUILDING												
9.	Improve academic achievement for all students.	2000 Grade 4 Grade 7 Grade 10	In development	X		•						•	
10.	Reduce the percentage of students at risk due to low commitment to school.	1998 Grade 6 - 35.2% Grade 8 - 39.4% Grade 10 - 42.5% Grade 12 - 47.3%	Grade 6 - 20% Grade 8 - 25% Grade 10 - 25% Grade 12 - 25%	X		•		•				•	
11.	Reduce the number of truant students defined as students who have five unexcused absences in a month or ten unexcused absences in a year.	In development	In development	X						•		•	
12.	Increase high school completion rate.	In development	In development	X		•						•	
	HEALTH												
13.	Reduce the proportion of youth reporting use during the past 30 days of: • Alcoholic beverages	2000 Grade 6 - 6.6% Grade 8 - 22.3% Grade 10 - 37.6% Grade 12 - 46.8%	Grade 6 - 4% Grade 8 - 15% Grade 10 - 25% Grade 12 - 35%		X	•	•	•			•	•	
	• Marijuana	2000 Grade 6 - 1.5% Grade 8 - 12% Grade 10 - 21.9% Grade 12 - 24.4%	Grade 6 - 0% Grade 8 - 5% Grade 10 - 10% Grade 12 - 10%		X	•		•					
	• Any illicit drug (includes marijuana)	2000 Grade 6 - 3% Grade 8 - 15.6% Grade 10 - 24.2% Grade 12 - 26.3%	Grade 6 - 0% Grade 8 - 5% Grade 10 - 10% Grade 12 - 10%		X	•		•					
	• Cigarettes	2000 Grade 6 - 4% Grade 8 - 12.5% Grade 10 - 19.8% Grade 12 - 27.6%	Grade 6 - 2% Grade 8 - 6% Grade 10 - 10% Grade 12 - 12%		X	•	•	•			•		
	• Smokeless tobacco	2000 Grade 6 - .8% Grade 8 - 2.1% Grade 10 - 4.6% Grade 12 - 8.8%	Grade 6 - 0% Grade 8 - 1% Grade 10 - 2% Grade 12 - 4%	X		•	•	•			•		

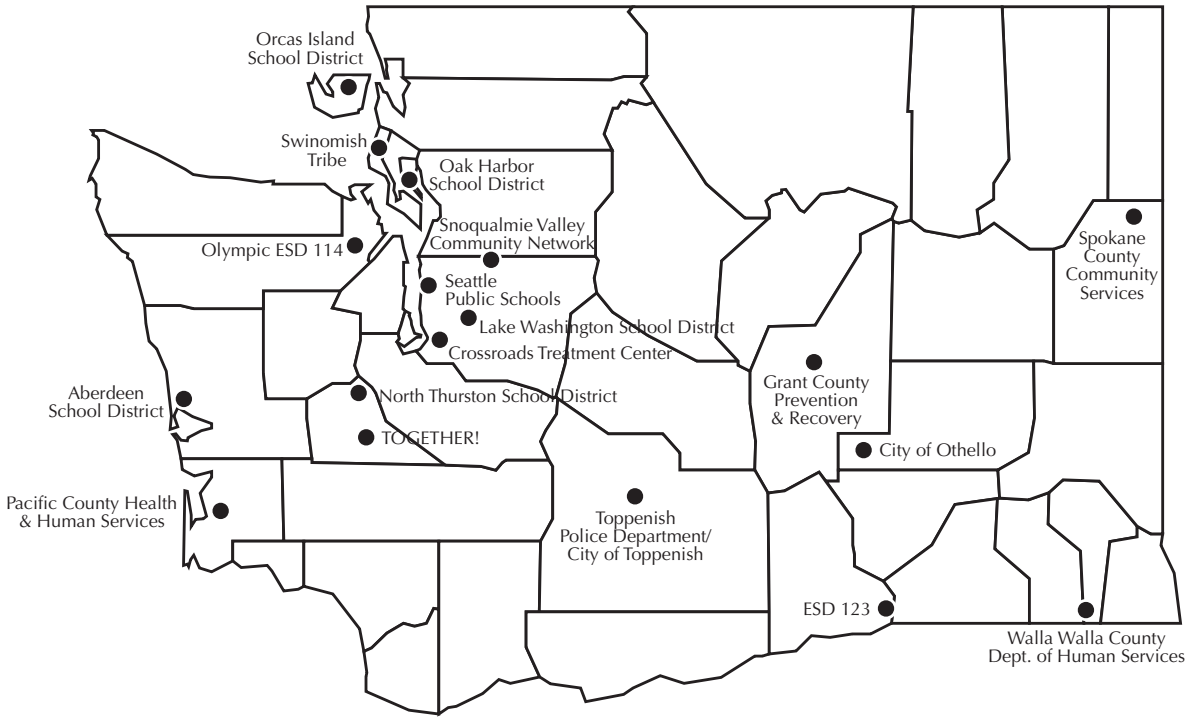
Agency Acronyms: CTED – Community, Trade and Economic Development • **GJJAC** – Governor's Juvenile Justice Advisory Committee • **DOH** – Department of Health • **LCB** – Liquor Control Board
DSHS – Department of Social and Health Services • **OSPI** – Office of Superintendent of Public Instruction • **FPC** – Family Policy Council • **WTSC** – Washington Traffic Safety Commission

#	Desired Outcome Objectives	Baseline	Targeted State Benchmarks	Long-range	Short-range	CTED	DOH	DSHS	FPC	GJJAC	LCB	OSPI	WTSC
	HEALTH (CONT.)												
14.	Reduce back to 1990 levels, the proportion of youth reporting binge drinking during the past two weeks	2000 Grade 6 - 4.7% Grade 8 - 14.9% Grade 10 - 23.2% Grade 12 - 31.8%	Grade 6 - 4% Grade 8 - 12% Grade 10 - 18% Grade 12 - 20%		X	•		•			•		
15.	Reduce the proportion of (college age), 18- to 24-year-olds reporting sometime in their lives: • Binge drinking	1998 37%	25%		X		•	•					
	• Use of marijuana	18%	15%										
	• Use of any illicit drug	21%	17%										
	• Use of cigarettes	37%	25%										
16.	Increase abstinence by pregnant women: • Any use in the past month • Binge drinking • Illicit drugs • Cigarette smoking	In development	In development	X	X	•	•	•					
17.	Increase the percentage of youth who perceive the harmfulness of: • Smoking one or more packs a day	2000 Grade 6 - 87.5% Grade 8 - 90.8% Grade 10 - 93.3% Grade 12 - 94.5%	Grade 6 - 100% Grade 8 - 100% Grade 10 - 100% Grade 12 - 100%	X		•	•	•				•	
	• Regular binge drinking	2000 Grade 6 - 69.4% Grade 8 - 71.8% Grade 10 - 76.8% Grade 12 - 73.7%	Grade 6 - 100% Grade 8 - 100% Grade 10 - 100% Grade 12 - 100%	X		•		•				•	
	• Regular marijuana use	2000 Grade 6 - 83.3% Grade 8 - 84.6% Grade 10 - 81.3% Grade 12 - 79%	Grade 6 - 100% Grade 8 - 100% Grade 10 - 95% Grade 12 - 95%	X		•		•				•	
18.	Increase the average age of first use of all substances to age 16: • Alcohol	1998 Age 14	Age 16	X		•		•					
	• Tobacco	Age 13	Age 16	X		•	•	•					
	• Marijuana	Age 14	Age 16	X		•		•					

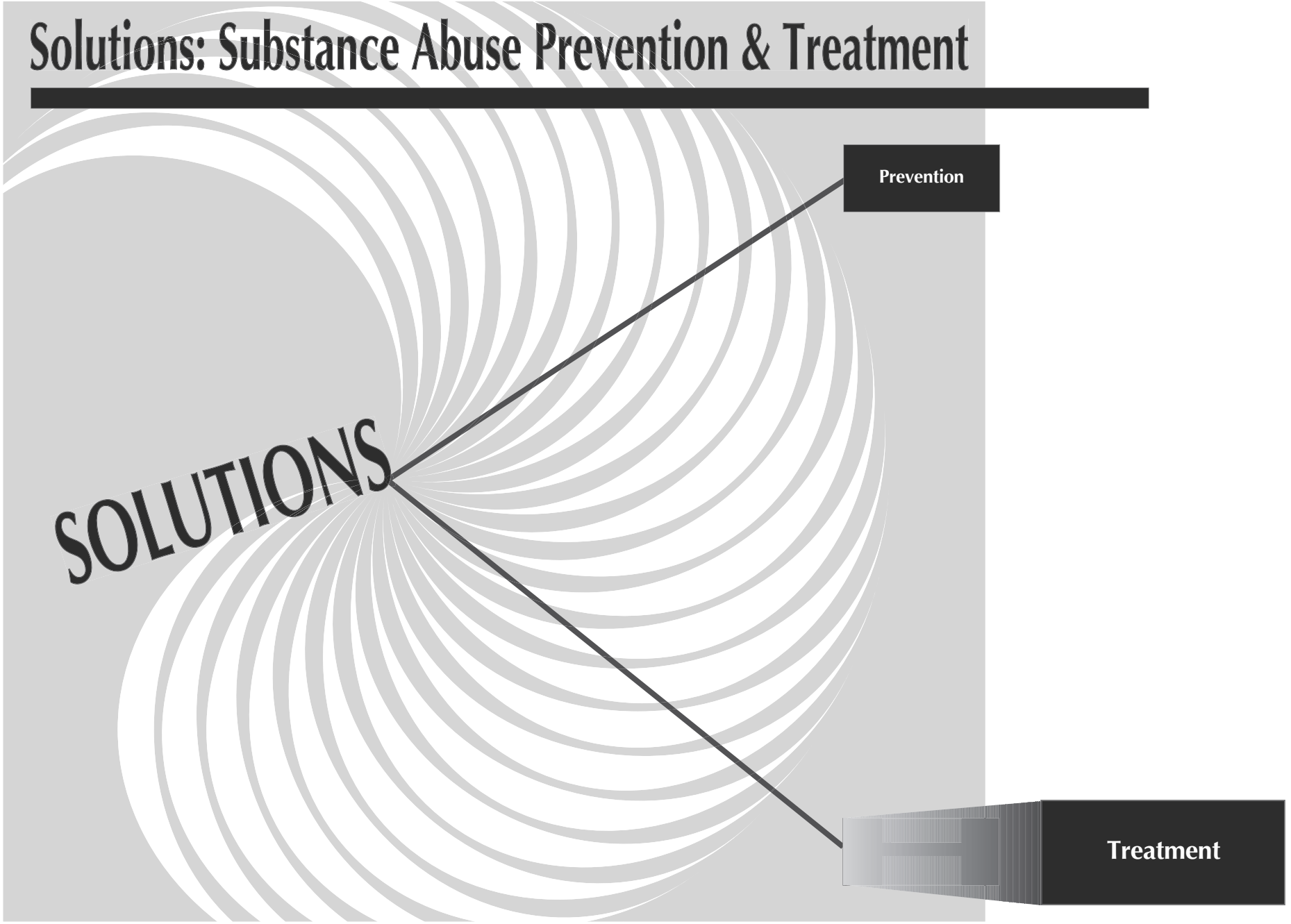
Agency Acronyms: CTED – Community, Trade and Economic Development • **GJJAC** – Governor's Juvenile Justice Advisory Committee • **DOH** – Department of Health • **LCB** – Liquor Control Board
DSHS – Department of Social and Health Services • **OSPI** – Office of Superintendent of Public Instruction • **FPC** – Family Policy Council • **WTSC** – Washington Traffic Safety Commission

State Incentive Grant Community Projects

For three years, 18 State Incentive Grant (SIG) communities from the state received funding to participate in a field-test of state- and community-level objectives included in the State Substance Abuse Prevention System Plan. These communities, in 15 counties, were able to demonstrate that they could establish successful partnership and coalitions to develop comprehensive community prevention action plans. Each community conducted a community needs assessment by collecting and reviewing data on alcohol, tobacco, and other drug use, and on risk and protective factors specific to their community. They used this data to target populations to receive prevention services, establish community-specific outcomes, and select and successfully implement evidence-based prevention services and activities. The SIG communities tested a web-based system to conduct their own outcome evaluations and used the results to reassess and revise community plans.



Solutions: Substance Abuse Prevention & Treatment



Introduction

Individuals are eligible for DASA-funded services if they are low-income or indigent, and are assessed as chemically dependent. For persons applying for treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), eligibility is further restricted to those who are unemployable as a result of their alcohol or other drug addiction. Treatment services are designed to maintain a cost-effective, quality continuum of care for rehabilitating alcoholics and drug addicts.

Contracted treatment services include:

- Diagnostic evaluation
- Alcohol/Drug detoxification
- Outpatient treatment
- Opiate substitution (methadone) treatment
- Intensive inpatient treatment
- Recovery house
- Long-term residential care
- Involuntary treatment/civil commitment for individuals with alcohol/drug addiction
- Youth residential treatment
- Youth outpatient treatment
- Residential treatment for pregnant and parenting women (with child care)
- Outpatient treatment for pregnant and parenting women (with child care)
- Treatment for co-occurring disorders
- Tribal treatment programs
- Monolingual programs for non-English speakers
- Treatment program for the deaf/hard of hearing
- Urine screening

Specialized contracted support services for eligible individuals include:

- Child care
- Translation services (including interpreters for persons who are deaf or hard of hearing)
- Transportation assistance
- Case management
- Youth outreach
- Cooperative housing (Oxford House) and other transitional housing support

State and federal funding requirements give priority for treatment and intervention services to the following:

- Pregnant and postpartum women and families with children
- Families receiving Temporary Assistance for Needy Families (TANF)
- Child Protective Services referrals
- Youth
- Injection drug users (IDUs)
- People with HIV/AIDS

DASA Treatment Philosophy for Alcohol, Tobacco, and Other Drug Addiction

DASA's program of substance abuse services is based on knowledge gained from medical research that alcoholism and addiction to other drugs is a progressive disease. Research and evaluation studies cited throughout this report indicate that long periods of sobriety, abstinence, and/or reduced drug use result from effective intervention and treatment. Research also demonstrates that treatment results in a marked reduction in negative consequences for the addicts, their families, friends, and society at large, as measured by domestic violence, disrupted families, employment histories, and public costs for law enforcement and the courts, welfare dependence, medical and hospital costs, and admissions to psychiatric hospitals.[1] As alcoholism and addiction are chronic, relapsing disorders, continued treatment and support services may be required after any initial course of treatment.

Alcohol, tobacco, or other drug addiction is an individual, family, worksite, and community affliction. These addictions negatively impact all sectors of society regardless of age, education, race/ethnicity, gender, occupation, or socio-economic status. Therefore, it is critical that all citizens – especially teachers, employers, parents, and youth – understand the illness is treatable and the channels for getting a person into private or public treatment agencies. DASA's philosophy recognizes the importance of ensuring all treatment agencies meet established standards for providing services. Treatment must be tailored to the specific needs of each individual, and a continuum of treatment services is essential for matching clients with the optimal types and sequences of treatments. It is also important that specialized treatment services be available for populations with special needs and circumstances, such as adolescents, pregnant and parenting women (and their children), members of minority populations, and those with disabilities.

DASA recognizes that substance abuse treatment cannot occur in isolation from law enforcement and public safety, educational institutions, and social, health, and economic services. It is essential that substance abuse treatment have linkages with all segments of society that are important to recovery and rehabilitation.

A key aspect of DASA's philosophy is recognizing the generational loop of addiction. It is important to break the generational cycle of addiction by promoting alcohol, tobacco, and other drug prevention programs, enrolling children of addicts in appropriate prevention activities, and providing early intervention services when needed.

[1]See, for example: Wickizer, T., and Longhi, D. (1997). Economic benefits and costs associated with substance abuse treatment provided to indigent clients through the Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Olympia, WA: Washington State Department of Social and Health Service, Division of Alcohol and Substance Abuse. See also: Schrager, L. Joyce, J., and Cawthon, L., (1995). Substance abuse, treatment, and birth outcomes for pregnant and postpartum women in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Planning, Research & Development and Office of Research & Data Analysis.

Current Need for Treatment

Defining Current Need for Treatment

Based on a 1999 study conducted by the Department of Social and Health Services, Research and Data Analysis[1] and subsequently updated with current population projections, 418,567 adults (age 18 and older) living in households in Washington State were estimated to be in need of substance abuse treatment in 2001. This represents 9.9% of the population of adults living in households. (The definition of need is provided on the following page.) Treatment need for adolescents (ages 12-17) living in households is estimated at 8.7%.

The largest number of adults in need of treatment experienced an alcohol-related disorder. Among adults, 6.8% (275,906) experienced an alcohol use disorder in the past 18 months, while 1.6% (67,915) experienced a drug use disorder during the same period.

Use rates among adults living in households for individual substances were as follows:

	Lifetime Use	Past 12-Month Use	Past 30-Day Use
Alcohol	92.3%	71.6%*	55.6%
Any Illicit Drug	40.2%	9.8%	4.9%
Marijuana	38.6%	9.0%	4.7%
Stimulants**	16.3%	1.9%	0.8%
Cocaine	12.5%	1.6%	0.5%

*past 18-month use measure utilized for alcohol only
***Includes amphetamine, methamphetamine, and other stimulants.*

[1] Holzer, C., Kabel, J., and Nordlund, D. (1999). Profile of substance use and need for treatment services in Washington State. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis.

Current Need for Treatment Among Population Subgroups in Washington State

Current estimated need for treatment varies across population subgroups:

- Compared with the overall treatment need rate of 9.9% of adults living in households, some subgroups have lower estimated rates of treatment need. These include: those ages 45-64 (4.9%) and 65+ (2.0%); females (6.3%); Blacks (7.5%), Asian-Pacific Islanders (2.0%), and Hispanics (7.5%); those who are married (6.0%); and non-high school graduates (9.3%).
- Other subgroups have higher estimated need for treatment. These include: those ages 18-24 (24.7%) and 25-44 (12.4%); males (13.5%); Native Americans (American Indians or Alaskan Natives) (17.4%); and those never married (22.0%).

Significantly, need for substance abuse treatment is not highly correlated with income. Compared with need for treatment among all adult household residents (9.9%), 11.1% of adults in households with incomes at or below 200% of the federal poverty line had a current need for substance abuse treatment in 2001.

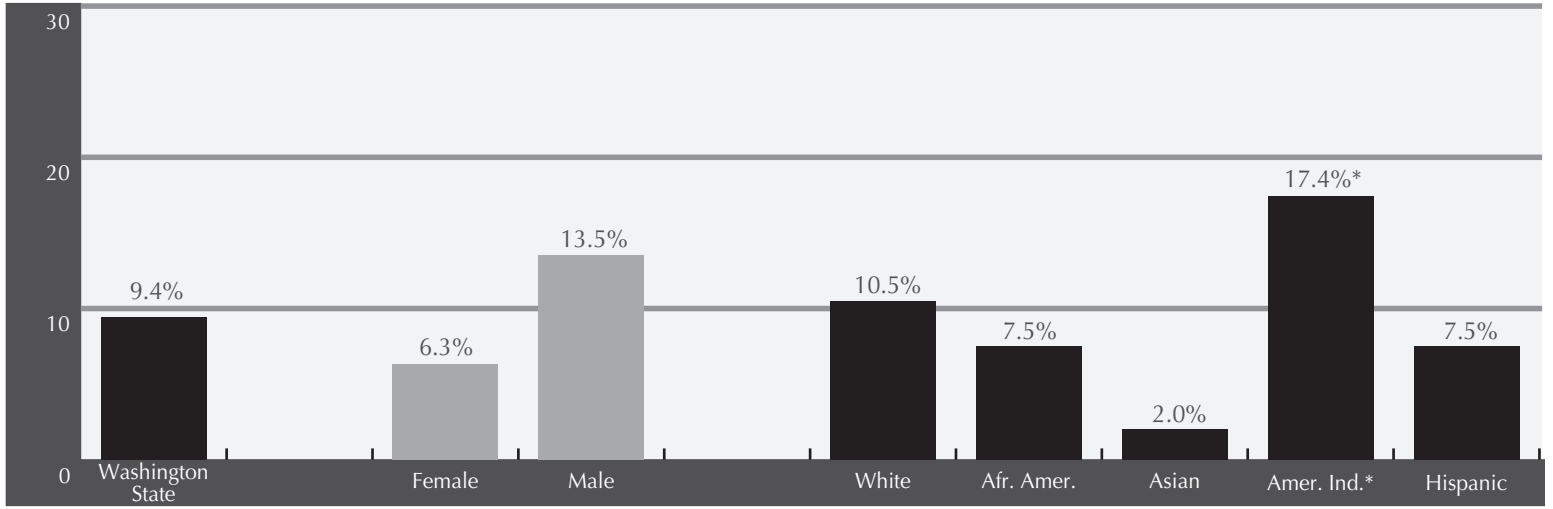
Those defined as currently in need of treatment met one of the following four conditions:

1. Individuals who had a substance use disorder in the past 18 months.
2. Individuals who did not meet the first condition but who reported that they have "had a problem or felt addicted to alcohol or drugs" AND reported drinking or using "regularly" during the past 18 months. "Regular" use means drinking three or more drinks per drinking day at least one or two times a week, OR using marijuana 50 times or more, OR using any other illicit drug ten times or more.
3. Individuals who did not meet the first two conditions but received licensed residential or outpatient treatment services (excluding detoxification or assessment) during the past 12 months.
4. Individuals who did not meet the first three conditions but used drugs or alcohol "heavily" during the past 18 months. "Heavy" use means drinking an average of four drinks per drinking day at least three to four times per week OR using any illicit drug 50 times during the past 18 months.

Persons Who are Female, Asian, or Hispanic Have LOWER Rates of Current Need for Substance Abuse Treatment. People Who are Male or American Indians* Have HIGHER Rates of Current Treatment Need.

Current Need for Treatment

Percent of Adults in Households



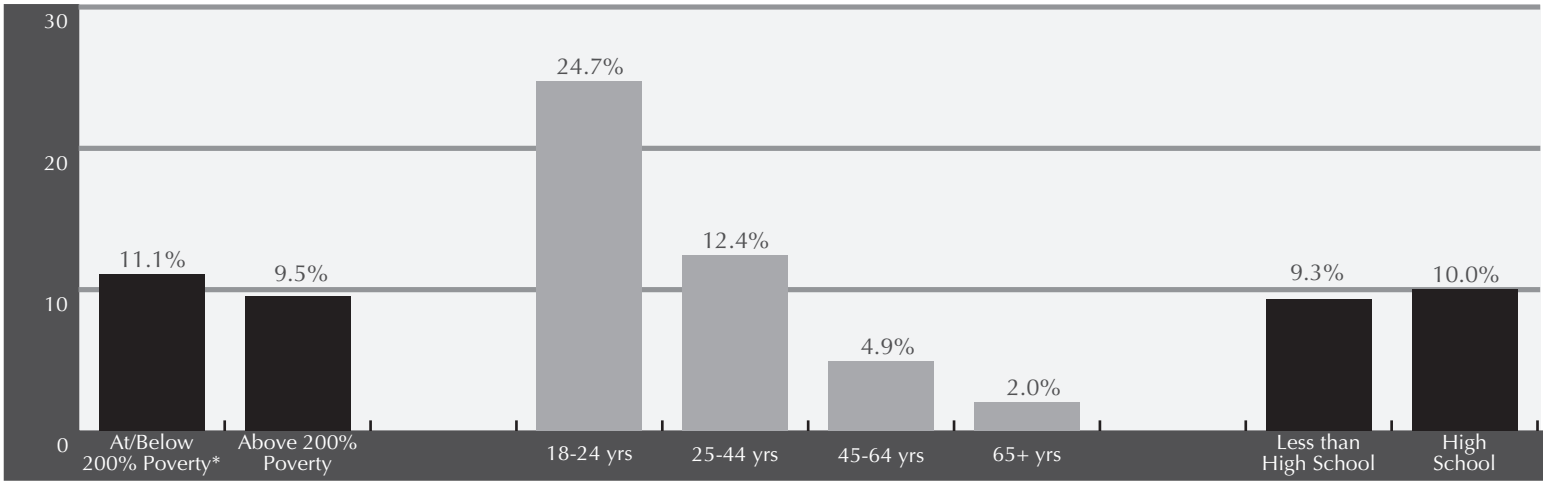
Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999); estimates updated for 2001.

*American Indian includes Alaskan Natives.
Note: for definition of Current Need for Treatment see page 164.

Persons Who are Age 45 and Older Have LOWER Rates of Current Need for Substance Abuse Treatment.

Current Need for Treatment

Percent of Adults in Household



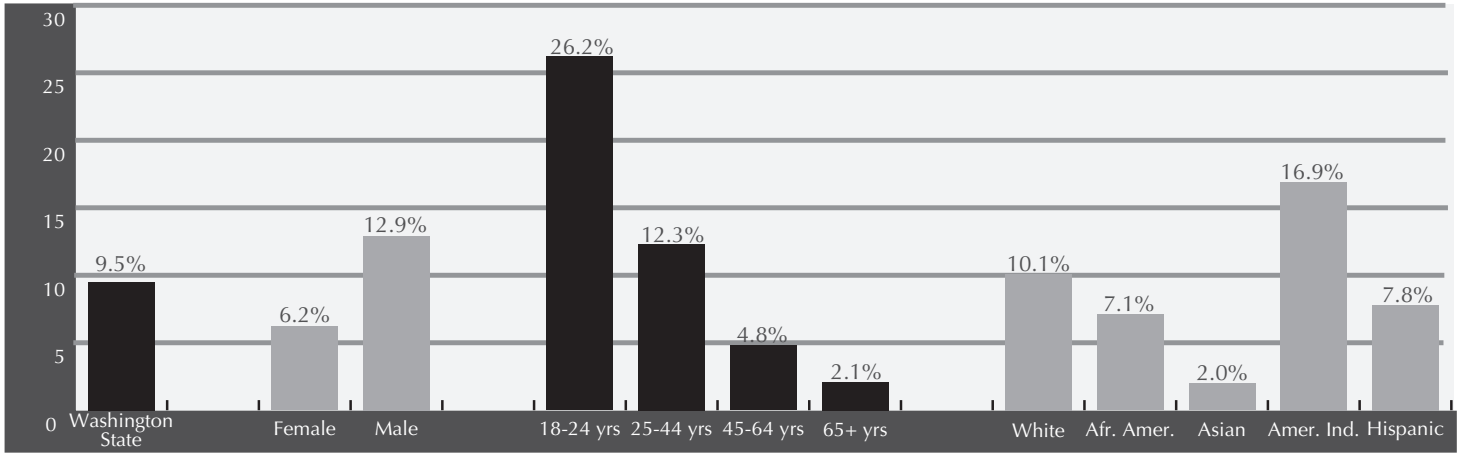
Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999); estimates updated for 2001.

*At/Below 200% of the Federal Poverty Level.
Note: for definition of Current Need for Treatment see page 164.

Adults With Incomes At/Below 200% of the Federal Poverty Level are Slightly More Likely to Have a Current Need for Treatment Than Those With Incomes Above 200% of the Federal Poverty Level.

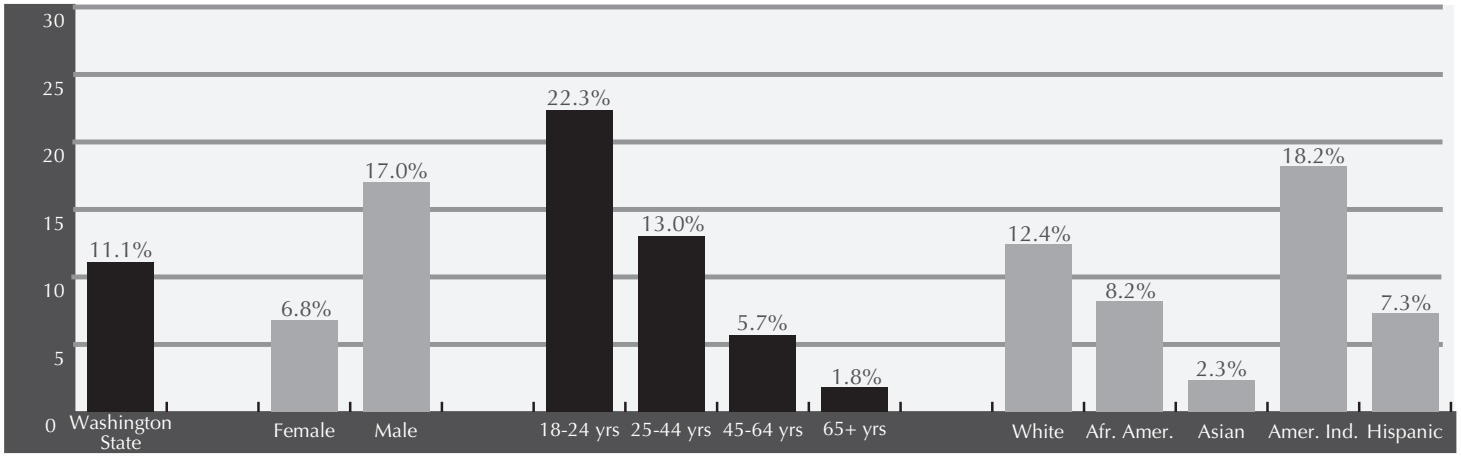
Current Need for Treatment for Adults above 200% of the Federal Poverty Level

Percent of Adults in Households



Current Need for Treatment for Adults at or below 200% of the Federal Poverty Level

Percent of Adults in Households



Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, Profile of Substance Use and Need for Treatment Services in Washington State (1999); estimates updated for 2001.

*American Indian includes Alaskan Natives.
Note: for definition of Current Need for Treatment see page 164.

Computing the DASA Treatment Gap

The Treatment Gap rate is a measure over a given period of time of those who qualify – both clinically and financially – for DASA-funded treatment services but who, because of the limits of available funding, do not receive it. To compute the treatment gap, an estimate is established of all those at or below 200% of the Federal Poverty Level (FPL) and in need of treatment. Those who are enrolled in the subsidized portion of the Washington Basic Health Plan (BHP) are subtracted from this number. Those receiving BHP with public subsidies would be expected to access chemical dependency treatment services without additional use of DASA funds.

The following equation is then used to compute the DASA Treatment Gap =

$$\textbf{DASA Treatment Gap Rate} = \frac{\text{\# of county residents qualifying for and requiring DASA-funded treatment minus those receiving it}}{\text{\# of county residents qualifying for and requiring DASA-funded treatment}} \times 100$$

The statewide treatment gap is computed by aggregating the county number and using the same formula. Counts of persons receiving DASA-funded treatment were drawn from DASA's TARGET management information service. These counts represent cases that were open in SFY 2001. Individuals must have received at least one residential or outpatient service during this period. Persons receiving more than one treatment service are only counted once.

Only those living in households are included. Those residing in institutions or group care settings are excluded from both the numerator and the denominator.* Results by county and statewide are displayed on the following page.

**For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance. Address and phone number are found on the back cover.*

The Treatment Gap

SFY 2002 Treatment Gap Rates in Washington State for Publicly Funded Chemical Dependency Services

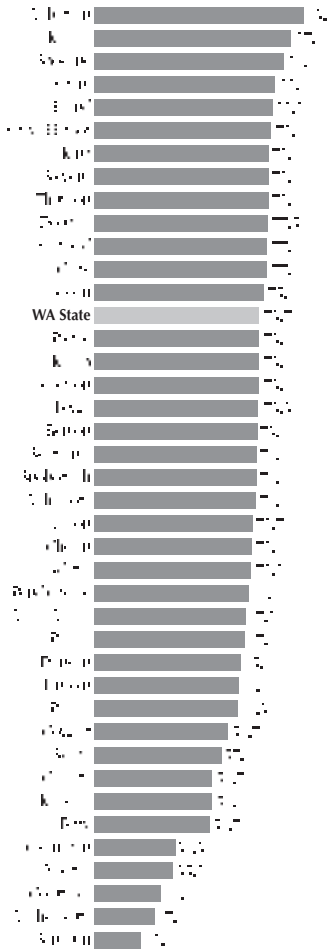
Target Population	Needing & Eligible for DASA-Funded Treatment	Received Treatment with DASA-Funded Support	Number of Eligible Individuals Unserved	Treatment Gap Rate (Unserved Need)
Adults w/children < 18	45,338	10,125	35,213	77.7%
Adults w/o children under 18	54,525	14,540	39,985	73.3%
ALL ADULTS 18 AND OLDER	**99,863**	**24,665**	**75,198**	**75.3%**
ADOLESCENTS (AGES 12 - 17)	**24,468**	**5,969**	**18,499**	**75.6%**
TOTAL	**124,331**	**30,634**	**93,697**	**75.4%**

Excludes detox and transitional housing, private-pay patients, and Department of Corrections.

**For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance. Address and phone number are found on the back cover.*

The Treatment Gap: Statewide, in SFY 2002, 75.3% of Adults in Households Who Qualified for and were in Need of DASA-Funded Treatment Did Not Receive It.

County	Number of Adults <200% FPL & eligible for DASA Services	Percent of Adults <200% FPL & in need of Treatment	Number of Adults <200% FPL Receiving Treatment	Number of Adults Not Receiving Treatment	Treatment Gap
Adams	3,082	7.83%	74	167	69.3%
Asotin	4,224	11.63%	99	392	79.8%
Benton	23,531	10.69%	726	1,789	71.1%
Chelan	14,461	9.84%	432	991	69.6%
Clallam	12,608	9.76%	501	730	59.5%
Clark	47,409	11.01%	1,105	4,115	78.8%
Columbia	882	8.38%	56	18	24.2%
Cowlitz	17,913	10.43%	753	1,115	59.7%
Douglas	6,629	8.64%	113	459	80.3%
Ferry	1,775	12.38%	104	116	52.7%
Franklin	13,160	7.42%	363	613	62.8%
Garfield	365	10.17%	21	16	43.4%
Grant	19,512	8.88%	352	1,381	79.7%
Grays Harbor	16,034	11.51%	350	1,496	81.0%
Island	11,170	11.48%	216	1,066	83.2%
Jefferson	5,708	10.79%	138	478	77.6%
King	199,155	11.53%	4,848	18,115	78.9%
Kitsap	31,151	11.27%	977	2,534	72.2%
Kittitas	8,125	16.88%	164	1,208	88.0%
Klickitat	4,487	9.44%	145	279	65.8%
Lewis	14,919	10.12%	378	1,132	75.0%
Lincoln	1,663	10.62%	47	130	73.4%
Mason	9,223	10.58%	260	716	73.4%
Okanogan	9,995	10.15%	518	496	48.9%
Pacific	5,235	8.47%	172	271	61.2%
Pend Oreille	2,774	9.90%	68	207	75.2%
Pierce	111,532	10.55%	2,945	8,822	75.0%
San Juan	1,337	10.64%	101	41	29.0%
Skagit	14,995	9.67%	576	874	60.3%
Skamania	2,122	9.19%	64	131	67.2%
Snohomish	63,386	11.29%	1,578	5,578	77.9%
Spokane	82,773	12.78%	1,615	8,963	84.7%
Stevens	7,968	11.05%	194	686	78.0%
Thurston	31,925	11.48%	848	2,817	76.9%
Wahkiakum	660	9.05%	47	13	21.3%
Walla Walla	9,395	11.12%	228	817	78.2%
Whatcom	27,295	14.21%	1,115	2,764	71.3%
Whitman	9,353	20.02%	103	1,769	94.5%
Yakima	50,125	8.38%	2,271	1,929	45.9%
Total	**898,053**	**11.12%**	**24,665**	**75,234**	**75.3%**



**For a fuller discussion of the methodology used to determine the treatment gap rate, contact the Office of Planning, Policy, and Legislative Relations, Division of Alcohol and Substance. Address and phone number are found on the back cover.*

Estimates of Substance Use and Treatment Need in Washington State, 2002

	Entire Adult Population	Adult Household Residents	Adults In Household At or Below 200% of Poverty
NEED FOR TREATMENT			
Current Need for Substance Treatment	454,729	426,368	112,379
ALCOHOL OR DRUG DISORDER			
Lifetime Alcohol or Drug Use Disorder	657,813	620,172	156,925
Past 18-Month Alcohol or Drug Use Disorder	339,943	314,393	80,994
ALCOHOL DISORDER			
Lifetime Alcohol Use Disorder	534,026	512,503	118,453
Past 18-Month Alcohol Use Disorder	313,454	292,859	68,845
DRUG DISORDER			
Lifetime Drug Use Disorder	220,742	206,724	68,845
Past 18-Month Drug Use Disorder	79,467	68,908	27,335
ALCOHOL USE			
Lifetime Use of Alcohol	4,079,320	3,975,127	877,768
Past 18-Month Use of Alcohol	3,169,862	3,083,631	583,154
Past 30-Day Use of Alcohol	2,467,901	2,394,551	428,254
USE OF ANY DRUG			
Lifetime Use of Any Illicit Drug	1,792,429	1,731,312	389,782
Past 12-Month Use of Any Illicit Drug	454,729	422,061	112,379
Past 30-Day Use of Any Illicit Drug	229,572	211,031	67,832
MARIJUANA USE			
Lifetime Use of Marijuana	1,721,791	1,662,404	368,521
Past 12-Month Use of Marijuana	419,411	387,607	100,230
Past 30-Day use of Marijuana	220,742	202,417	60,745
STIMULANT USE			
Lifetime Use of Stimulants	741,695	702,000	201,472
Past 12-Month Use of Stimulants	88,297	81,828	30,373
Past 30-Day Use of Stimulants	39,734	34,454	9,112
COCAINE USE			
Lifetime Use of Cocaine	569,516	538,343	128,577
Past 12-Month Use of Cocaine	75,052	68,908	26,323
Past 30-Day Use of Cocaine	26,489	21,534	7,087

Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, *Profile of Substance Use and Need for Treatment Services in Washington State* (1999), estimates updated for 2002.

Estimates of Current Need for Substance Abuse Treatment in Washington State, 2002

	Entire Adult Population*			Adult Household Residents			Adults In Household at or below 200% Poverty		
GROUP	**Population**	**# Needing Treatment**	**% Needing Treatment**	**Population**	**# Needing Treatment**	**% Needing Treatment**	**Population**	**# Needing Treatment**	**% Needing Treatment**
Total	4,414,849	454,520	10.3	4,306,747	422,685	9.8	1,012,420	112,409	11.1
AGE									
01-17	Not Available			Not Availalbe			Not Available		
18-24	572,727	145,702	25.5	529,624	130,585	24.7	197,620	43,984	22.3
25-44	1,714,137	221,079	12.9	1,687,415	208,497	12.4	400,136	51,869	13.0
45-64	1,451,419	72,938	5.0	1,443,059	70,435	4.9	232,287	13,187	5.7
65+	676,566	14,801	2.2	646,649	13,168	2.0	182,376	3,369	1.9
SEX									
Male	2,177,820	312,211	14.3	2,112,056	284,538	13.5	432,412	73,123	16.9
Female	2,237,029	142,310	6.4	2,194,691	138,148	6.3	580,008	39,286	6.8
ETHNICITY									
White	3,738,984	406,882	10.9	3,654,653	381,464	10.4	764,186	94,575	12.4
Black-NH	132,936	12,376	9.3	123,427	9,205	7.5	42,443	3,475	8.2
Asian	246,233	5,221	2.1	241,677	4,930	2.0	70,876	1,643	2.3
Amer. Indian**	58,379	10,664	18.3	56,757	9,875	17.4	26,231	4,766	18.2
Hispanic	238,318	19,377	8.1	230,233	17,211	7.5	108,684	7,950	7.3
MARITAL									
Married	2,696,468	163,371	6.1	2,681,668	160,771	6.0	424,503	29,637	7.0
Div/Sep/Wid	869,488	94,881	10.9	836,075	88,291	10.6	320,115	28,641	9.0
Never Mar	848,894	196,268	23.1	789,005	173,622	22.0	267,802	54,095	20.2
EDUCATION									
Not HS Grad	805,663	78,446	9.7	777,151	72,168	9.3	334,312	19,976	6.0
HS Graduate	3,609,186	376,074	10.4	3,529,597	350,517	9.9	678,107	92,433	13.6
POVERTY									
Below 200%	1,116,101	143,087	12.8	1,012,420	112,409	11.1	1,012,420	112,409	11.1
Above 200%	3,298,748	311,433	9.4	3,294,328	310,276	9.4	-	-	-
RESIDENCE									
Residential	4,306,747	422,685	9.8	4,306,747	422,685	9.8	1,012,420	112,409	11.1
Institutional	51,185	17,715	34.6	-	-	-	-	-	-
Group quarters	56,916	14,121	24.8	-	-	-	-	-	-

*Includes institutions and group quarters

**American Indian includes Alaskan Native.

Source: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse and Office of Research and Data Analysis, *Profile of Substance Use and Need for Treatment Services in Washington State* (1999), estimates updated for 2002.